DOME HOME CARE
24 15TH STREET SUITE #205
BROOKLYN, NY 11215
(718) 854-5501
Provider # 4450490001

DURABLE MEDICAL EQUIPMENT STATEMENT OF ORDERING PHYSICIAN

Beneficiary Name: _____ Date: ___/___/___

Address: _____ HICN: _____

City, State, Zip: _____ DOB: ___/___/___

DIAGNOSIS (ES): _____ Date last seen: _____

HCPCS CODE	ITEM DESCRIPTION	QTY
E0570	NEBULIZER COMPRESSOR	1
A7003	NEB KIT	4
A7015	AEROSOL MASK	1
A7013	FILTER, DISPOSABLE	2
A7014	FILTER, NON DISPOSABLE	2

THE ABOVE IS MEDICALLY NECESSARY BECAUSE:

PATIENT HAS A MEDICAL CONDITION WHICH REQUIRES THE ADMINISTRATION OF INHALATION THERAPY. USE OF AN MDI HAS BEEN CONSIDERED, BUT RULED OUT.

INHALATION SOLUTION(S) PRESCRIBED:

A) _____

B) _____

PRESCRIBED DOSAGE PR TREATMENT

A) _____

B) _____

TREATMENTS PER DAY:

A) _____

B) _____

PHYSICIAN NAME: _____ LIC #: _____

ADDRESS: _____ NPI#: _____

CITY, STATE, ZIP: _____ PECOS: ☐ YES ☐ NO

_____ _____

PHYSICIAN SIGNATURE DATE

**NOTE TO PHYSICIAN: BY SIGNING THIS DOCUMENT YOU ARE VERIFYING THERE IS SUPPORTING DOCUMENTATION IN PATIENT'S PERMANENT MEDICAL RECORDS AND THIS INFORMATION IS AVAILABLE UPON REQUEST.